PRINTED: 01/08/2010
FORM APPROVED

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TN1903	A. BUILDING _____ B. WING _____	01/06/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHANY HEALTH CARE CENTER	421 OCALA DRIVE NASHVILLE, TN 37211

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 000	Initial Comments During annual licensure survey conducted on January 4, 2010 at Bethany Health Care and Rehab, no deficiencies were cited in relation to 1200-8-6, Standards for Nursing Homes.	N 000		

Preparation and submission of this plan of correction does not constitute an admission or agreement by the provider that a deficiency exist. The plan of correction is prepared and submitted as a requirement under state and federal law.

REGULATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE NHA | (X6) DATE 1/21/10